



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

East Texas Medical Center

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-16-0004-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

September 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is correct amount per the APC allowable per the new fee schedule that started 3/01/2008 for the following HCPC's."

Amount in Dispute: \$49.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the MAR calculation and disagrees with the Provider's calculations."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2014	93005	\$49.06	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Allowance included in another service
 - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
 - W3 – Additional payment made on appeal/reconsideration
 - 975 – Charge is included in the basic surgical allowance

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Allowance included in another service." 28 Texas Administrative Code §134.203(b) requires that

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Per Medicare CCI coding edits, procedure code 93005 may only be reported with procedure code 26540 billed on the same claim when submitted with the -59 and "Documentation that supports a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual." Insufficient documentation was found to support the requirements of -59 modifier were met. Therefore, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Pursuant to Rule 134.203 (b) separate reimbursement for services in dispute is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 2, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.